The Royal College of Emergency Medicine

COVID19: Resetting Emergency Care

What to do if your ED is becoming crowded again after the initial COVID period

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Crowding is returning to Emergency Departments (EDs) in the UK and there are significant concerns about how the situation is developing. Crowding remains a major threat to patient and staff safety, and it can only be tackled through clear and consistent system leadership, backed up by meaningful action. This element of 'Resetting Emergency Care' aims to support leaders in systems, organisations, and Emergency Medicine to consider their current position, and work together in the face of this re-emerging problem.

Advocacy

- Crowding kills. ED crowding was not acceptable before COVID, and it is even more dangerous in the presence of COVID.
- RCEM advocacy on this issue (CARES) is available here. There is post-COVID RCEM guidance available here, and RCEM IPC guidance here. Pre-existing College guidance on crowding is here.
- The need for regional and local advocacy is inversely related to the effectiveness of the system and organisation, whether there is recognition of the harmful effects of crowding, and whether there is acceptance of the fact that the causes, and necessary responses, lie largely outside of the control of the ED itself.
- System and organisational leaders should be prioritising and re-orientating services around this issue within their overall context. EM leaders should ensure that they are fully engaged with their line and organisational management, and with any planned changes in the wider system.
- There is a strong ethical obligation both to prevent and manage ED crowding based on beneficence, non-maleficence and justice.
- There is also a legal obligation to avoid crowding where this may conflict with organisations' obligation to protect the health and safety of staff, patients and visitors.

- Narratives around safety, and both patient and staff experience are extremely useful to help others to understand the problems that have to be resolved.
- If loss of inpatient or procedural capacity due to IPC measures, designed to protect patients and staff, is part of the problem … then the same considerations apply in all areas of the ED. This is especially true since ED patients are undifferentiated and not tested for COVID-19 or other infectious diseases. ED patients and staff have the same right to a safe experience as other groups.
- It is neither reasonable nor sensible for the ED to be expected to "cope" without being part of a wider organisation and system response, or to be regarded as still having elastic walls. EDs cannot pick up the pieces of a failing system where it results in crowding, given the attendant risks to patients and staff, and to organisational performance and reputation.
- EM leaders have a duty to act as advocates for their patients and staff, so that NHS bodies can plan and respond appropriately. They also have a duty to work within existing risk management systems, and to warn when crowding is becoming dangerous.
- Advocacy can sometimes mean asking uncomfortable questions, particularly around evening and weekend operations.

Has your ED adopted relevant good practice?

- Are ED IPC measures up to scratch?
- Do you know what space, staff and informatics support you require to run your ED safely and effectively? Has the case been made, and considered at the appropriate level with the appropriate level of support?
    - If the ED footprint has adapted to cope with COVID, have staffing requirements in all groups been changed to reflect this?
    - Can you treat critically ill patients with infectious disease safely in the ED?
- Do you know the current safe physical capacity of ED (including waiting and ambulatory areas) and how it differs from the position pre-COVID?
- Are ED internal processes as efficient, effective and consistent as they need to be?
    - Is there organisational support to break down barriers?
- Have EM leaders agreed a departmental philosophy and escalation procedure around imminent crowding? (It is important from both an ED and organisational perspective for EM senior staff to present a consistent and united front).
- Has the organisation's existing risk management structure been fully utilised?
    - It is the responsibility of the organisation to respond appropriately.

Is your organisation doing all it can to reduce crowding?

EDs crowd when:

1. There are too many patients to manage with the available staff
2. There are too many patients to be managed within the available space
3. There are internal hold-ups such as waiting for imaging or specialist opinions, disagreements with teams about accepting patients, or overly complex systems
4. There is exit block or slow flow
5. A combination of the above. Exit block will trump everything.

It is wise for organisational and system leaders to be asking where they are with respect to the following domains. EM leaders should be asking how they can support efforts, but they should be led by senior and empowered organisational leaders.

- Setting up effective 111 (or equivalent), primary care and community options, combined with accessible alternatives to ED. These all need to work when patients actually present and need them, rather than just during traditional 'working hours'.
- Recalibrating pathways that lead to patients coming through ED by default. This includes those referred to the take, to specialist teams or those needing a swab before they go to a protected ward. Examples:
    - Are community services supported to refer patients to appropriate teams and areas, using simple and effective systems, to facilitate by-pass of the ED?
    - Have inpatient teams got accessible assessment areas that are not the ED?
    - Does post-discharge / post-op information include contact details for specialist teams, and plans that work 24/7, rather than simply defaulting to ED?
    - Are ED triage and initial assessment teams supported and empowered to safely stream to the most appropriate service?
- Ensuring ambulatory care becomes part of the DNA of the local NHS. In the first instance this means developing accessible 7-day, extended hours, SDEC options for every speciality. These need to have adequate capacity and be accessible from primary and other pre-hospital care.
    - EDs can then also stream to these services or use them as alternatives to admission.
- Getting staffing right across the acute pathway based on the level and expected variation in demand AND the physical footprints.
- Aiming for safe bed occupancy levels, which requires enough staffed beds, and optimised length of stay.
- Ensuring the organisation's informatics infrastructure supports effective clinical and managerial practice.
- Ensuring the organisation's managerial infrastructure and culture supports innovation and flexibility.

- Getting acute pathways, particularly for medicine, running effectively. This needs to include evenings and weekends. There's a joint RCEM/RCP/ RCGP/ SAM statement here.
- Developing 7-day 24/7 responses and/or pathways from specialist teams who do not currently provide such a response.
- Ensuring early senior opinions are available from the right specialist teams when patients need them, at the time they need them, to avoid admission or to optimise care early in the inpatient pathway.
- Developing and supporting an effective set of professional standards for the whole organisation, including actions when patients are ready-for-ward.
- Adopting policies across the organisation so that patients aren't held up in the ED or other assessment areas waiting for non-critical diagnostics or opinions.
- Improving pathways for patients with mental health problems both out of hospital & in the ED.
- Improving systems around patients who attend frequently.
- Ensuring access to all necessary diagnostic tests 7/7, together with early reporting.
- Ensuring that the wards and wider system are running to good practice 7/7 with particular attention to progressing care and supporting (early) discharge, and ensuring that there is flow across the week not just during the 'working week'.
- Ensuring transport or drug availability issues don't stop patients being discharged when they are ready, either from the ED or hospital.
- Ensuring that escalation plans have clear triggers (and that they have changed to reflect post-COVID world), clear responses and accountability. Such plans should:
    - Reflect post-COVID safe capacity and triggers.
    - Contain clear actions and where possible avoid discretionary effort.
    - Work effectively 7-days 24/7. 'Tumbleweed plans' are pointless.
    - Ensure the organisation's escalation response enables it to bring in additional staff when needed, including evenings, weekends and bank holidays (this may need to backed up by facilitatory financial and HR policies).
    - Involve not just the organisation, but the local health community.
    - Answer the most difficult questions about what happens when assessment areas, or the hospital, are predicted to be full. This doesn't mean the ED should be allowed to crowd and may include developing as a least-worst escalation option a post-ED cohort area (not a pre-ED holding area). Such an area should not be the responsibility of EM clinicians or of ED staff. RCEM's view on holding ambulances, pre-ED areas, and post-ED areas are here.
        - Is there a big button to press when you see that ambulances will not be able to offload, and does it make a real difference when you do press it?

What should local EM leaders do if they feel that organisations are not responding effectively?

- Existing risk reporting and management structures should be fully utilised, including the risk register.
- Local escalation routes include line management, and organisational management. These should always be fully exhausted first.
- All organisations have alternative routes for raising concerns around safety.
- Regulatory authorities in the UK which are available to be contacted are listed here. This doesn't just include healthcare regulators. If your concerns are about Health and Safety at work the Health and Safety Executive may be appropriate.
- Health Professionals have a duty to report patient safety concerns and this may include going to their professional lead in the organisation, or potentially their professional regulator if they feel their concerns are not being addressed.
- Consultant teams should consider flagging up their concerns collectively where practical so that issues are raised impersonally and with more authority.
- RCEM is always ready to discuss concerns and offer advice and support to Members and Fellows. You can either go through your regional leads or contact the VPs or President directly.

Please send any comments or feedback to Ian Higginson via vicepresident@rcem.ac.uk